

HEALTH HISTORY						
Name		Grade (As of Next Sport Season)				
Address		Sex	M / F	Age	Date of Birth	
School Sports		Fall		Winter	Spring	
IN CASE OF EMERGENCY, CONTACT:						
Name		Relationship:		Home Phone :		
Work Phone		Mobile Phone:		Beeper:		
Personal Physician Name		Address:		Phone:		
ALL "YES" ANSWERS MUST BE EXPLAINED (BOX ON BOTTOM		YES	NO		YES	NO
1. Have you had an illness or injury since your last physical?				33. Do you wear glasses, contacts, or protective eyewear?		
2. Have you ever been hospitalized overnight?				34. Do you have any other problem with your eyes or vision?		
3. Have you ever had surgery?				35. Have you had dental health problems, or loss of tooth enamel?		
4. Are you currently taking any prescription or nonprescription (over the counter) medications or pills or using an inhaler?				36. Have you broken or fractured any bones or dislocated any joints, or been diagnosed with a stress fracture?		
5. Have you ever taken any supplements or vitamins to help you improve your performance?				37. Have you ever had a sprain, strain, or swelling after Injury or any other problems with pain or swelling in muscles, tendons, bones, or joints that has kept you from participating in sports?		
6. Do you have any allergies?				<i>If yes, check appropriate box and explain below</i>		
7. Have you ever had a rash or hives develop during or after exercise?				<input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Hip		
8. Have you ever been dizzy or passed out during or after exercise?				<input type="checkbox"/> Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh		
9. Have you ever had chest pain during or after exercise?				<input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee		
10. Have you ever had high blood sugar (diabetes)?				<input type="checkbox"/> Chest <input type="checkbox"/> Hand <input type="checkbox"/> Shin/Calf		
11. Do you tire more easily than you feel you should?				<input type="checkbox"/> Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Ankle		
12. Have you ever been diagnosed with anemia?				<input type="checkbox"/> Upper Arm <input type="checkbox"/> Foot		
13. Have you ever had racing of your heart or skipped heartbeats?				38. Have you experienced abdominal discomfort, constipation, diarrhea, and/or bloating?		
14. Have you had high blood pressure?				39. Do you lose weight regularly to meet weight requirements for your sport?		
15. Have you ever been told you have a heart murmur?				40. Has there been any unexplained weight loss or weight gain during the past six months?		
16. Before the age of 50 has any family member or relative died of heart problems or of sudden death ?				41. Are you uncomfortable with your body weight?		
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?				42. Are you currently following any particular diet or weight reducing plan?		
18. Has a physician ever denied or restricted your participation in sports for any heart problems?				43. Do you diet frequently?		
19. Have you ever been diagnosed with blood or bleeding disorders?				44. Do you avoid eating certain food groups?		
20. Do you have one kidney or one testicle?				45. Have you ever tried to control weight by vomiting, using laxatives, diuretics or diet pills?		
21. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?				46. Do you have a history of eating disorders?		
22. Have you ever had a head injury or concussion?				FEMALES ONLY		
23. Have you ever been knocked out, become unconscious, or lost your memory?				47. Has there been a recent change in menstrual patterns?		
24. Have you ever had a seizure or convulsion?				48. At what age did you experience your first menstrual period?		
25. Do you have frequent or severe headaches?				49. When was your most recent menstrual period?		
26. Have you ever had numbness or tingling in your arms, hands, legs, or feet from a stinger, burner, pinched nerve, or other condition?				50. How much time do you usually have from the start of one period to the start of another?		
27. Have you ever had heat cramps, heat exhaustion, or heat stroke?				51. How many periods have you had in the last year?.		
28. Do you cough, wheeze, or have trouble breathing during or after activity?				52. What was the longest time between one menstrual cycle and the next in the last year?		
29. Do you have asthma or lung disease?						
30. Do you have seasonal allergies that require medical treatment?						
31. Do you use any special protective or corrective equipment/ devices that aren't usually used for your sport or position (ex., knee brace, foot orthotics, retainer on your teeth, hearing aid)?				Explain "Yes" Answers Here (Identify each answer with question number)		
32. Have you ever had any problem with your ears or hearing?						

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Date _____

Athlete Signature _____ Parent/Guardian Signature _____